Kidney Transplant Services Recipient Evaluation
Background Information Form/Social Worker Assessment

*Please read before completing this form*

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This form is intended for potential transplant recipients.

You may complete this form, to the best of your ability, and mail or fax to Presbyterian Transplant Services.

Address: Presbyterian Transplant Services
201 Cedar Ave SE, Suite 820
Albuquerque, NM 87106

Fax number: (505) 222-2149

*Please use this as the cover sheet when sending completed form.*

If you would like to speak with a Transplant team member before completing this form, please call (505) 841-1434.

Once we receive the completed form, a Transplant team member will contact you to complete a new patient intake and schedule you to attend the Transplant Orientation Class.
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Instructions: Please fill out all the items on this form. Please print your name at the bottom right of each page.

PATIENT INFORMATION

Name: __________________________________________ Date: ______________

Address: ________________________________________ City: __________ State: ______ Zip Code: ______

Home Phone: ___________________ Work Phone: ___________________ Cell: ___________________

Social Security #: ___________________________ DOB: _______________ Age: __________

Birthplace: __________________________ A Are you a US Citizen? Yes ☐ No ☐

Immigration Status: __________________________ Are you a Veteran? Yes ☐ No ☐


Primary Language Spoken: __________________ Language of Origin __________________

Relationship Status: Single ☐ In Relationship ☐ Life Partner ☐ Married ☐ # of Years ________

Emergency Contact: __________________________ Emergency Phone #: ____________

Relationship to emergency contact: ____________________

Do you live in: House ☐ Apartment ☐ Mobile Home ☐ Own ☐ Rent ☐

Who do you live with? (List Names & Relationships):

________________________________________________________________________________________

Do you have pets? Yes ☐ No ☐ Please List: ____________________________

EMPLOYMENT/EDUCATION

Highest Level of Education Completed: ____________________________

Your Usual Occupation: ____________________________ Currently Employed? Yes ☐ No ☐

If yes, where? ____________________________ For how long? ____________

☐ Full Time ☐ Part Time

If No, when and where did you last work? __________________________

Reason for leaving: ____________________________
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Are you on disability? Yes ☐ No ☐ Type of benefit (SSD, SSI, etc.): __________________________

If so when was your disability start date_________________ Cause of disability: __________________________

SPOUSE / SIGNIFICANT OTHER

Spouse/ Significant other's name: ___________________________ DOB: ___________________________

Highest level of education completed: ___________________________

Employer: ___________________________ Currently employed Yes ☐ No ☐

Position: ___________________________

FAMILY INFORMATION

Mother's Name: ___________________________ Living ☐ Deceased ☐

Father's Name: ___________________________ Living ☐ Deceased ☐

Do you have brothers and sisters? Yes ☐ No ☐

Names and ages of brothers and sisters?
______________________________________________________
__________________________________________________________________________________________________

Do you have children? Yes ☐ No ☐

Name & Ages of Your Children: ___________________________
__________________________________________________________________________________________________

Significant information about your children:
______________________________________________________
__________________________________________________________________________________________________

Describe your relationship with your family: ___________________________
__________________________________________________________________________________________________

Who do you most often look to for emotional support? ___________________________
__________________________________________________________________________________________________
INSURANCE INFORMATION

Primary Insurance Company: ___________________________________________ ID # _____________________________
Secondary Insurance Company: ___________________________________________ ID # _____________________________
Name of your prescription plan? _________________________________ Medication co-pay? ______________
Have you ever applied for, or been on Medicaid? Yes ☐ No ☐

LIVING WILL

Do you have a living will? Yes ☐ No ☐ Do you have a durable power of attorney? Yes ☐ No ☐

RENAL MEDICAL HISTORY

Cause of your renal failure? ____________________________________________
Are you on dialysis? Yes ☐ No ☐ Type of dialysis: Hemo ☐ PD ☐
Dialysis Center: _______________________________ Date dialysis started: ____________________
How is dialysis going? ____________________________________________

Do you or have you ever had a weight problem? Yes ☐ No ☐ When? _______________________________
Are you on a special diet? Yes ☐ No ☐ If yes, what kind? Renal ☐ Diabetic ☐ Other __________

LIFESTYLE

How has your illness affected your lifestyle? ____________________________________________

How do you cope with your illness and lifestyle changes? ________________________________

What are your hobbies and activities? ____________________________________________

What are the main causes of stress in your life? ____________________________________________

How do you handle stress? ____________________________________________

Have you ever been depressed? Yes ☐ No ☐ Have you ever attempted suicide? Yes ☐ No ☐
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Have you ever had problems with anxiety? Yes ☐ No ☐

Have you ever participated in counseling? Yes ☐ No ☐ If yes, When? _______________________
Why? ___________________________________________ Was it helpful? Yes ☐ No ☐

Were you treated with medication or therapy? Yes ☐ No ☐

Are you open to counseling? Yes ☐ No ☐

Have you even been hospitalized for psychiatric reasons? Yes ☐ No ☐

Are you sexually active? Yes ☐ No ☐ If yes, do you use protection/birth control? Yes ☐ No ☐

If yes, what type of protection/birth control do you use? ___________________________________________

Do you smoke now? Yes ☐ No ☐ How much? ___________________________________________

Have you ever smoked/chewed tobacco? Yes ☐ No ☐ For what time period? _______________________

If yes when did you quit? _______________ Are you interested in a smoking cessation program? Yes ☐ No ☐

Do you currently drink alcohol? Yes ☐ No ☐

Beer: Yes ☐ No ☐ Wine: Yes ☐ No ☐ Mixed Drink: Yes ☐ No ☐ Other: Yes ☐ No ☐

How often? Daily ☐ Weekly ☐ Occasionally ☐

Did you drink in the past? Yes ☐ No ☐ How Long? _______________ How much? _______________

Have you ever had a DWI (Driving While Intoxicated/Impaired)? Yes ☐ No ☐

Have you ever been called a “problem drinker” or “alcoholic”? Yes ☐ No ☐

Have you ever participated in AA? Yes ☐ No ☐

Have you ever been in court ordered treatment? Yes ☐ No ☐

Do you use recreational drugs? Yes ☐ No ☐ Type (Pot, Crack, Cocaine, etc.) _______________________

Did you in the past? Yes ☐ No ☐ If yes, what and when? _____________________________

Have you ever served time in jail/prison? Yes ☐ No ☐

When? _____________________________ Why? ___________________________________________

Have you ever been on Probation/Parole? Yes ☐ No ☐

When? _____________________________ Why? ___________________________________________
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MEDICATIONS

Who keeps track of your medications?

Self ☐ Spouse/Life Partner ☐ Family Member ☐ Other ☐

Do you know your medications? Yes ☐ No ☐

Do you sometimes forget to take your medication? Yes ☐ No ☐ If so how Often? ______________________

POST-TRANSPLANT CARE

Who will provide care and support to you during the transplant experience? _____________________________________________________________

__________________________________________________________

Who will care for you after your transplant? _______________________________ Relationship: _____________

Who will provide transportation after your transplant? ______________________ Relationship: ______________ 

Does your support person have vacation time, or the ability to take a leave of absence, to assist you during and after your transplant? Yes ☐ No ☐

If you live outside of the Albuquerque area, will staying in Albuquerque after your transplant be a financial strain for you? Yes ☐ No ☐

Do you, or your family need assistance with lodging accommodations during your transplant recovery period? Yes ☐ No ☐

What are your main concerns about being a candidate for a transplant? __________________________________________________________

________________________________________________________________________

__________________________________________________________

POTENTIAL DONOR(S)

Do you know anyone who wants to donate a kidney to you? Yes ☐ No ☐

If yes, who and your relationship to them?____________________________________________________________

________________________________________________________________________

Are you comfortable accepting a living donor kidney? Yes ☐ No ☐

Who filled out this background information form? Self ☐ Other ☐